1246

So, notions of what is liability is, to me -- you know, I'm not a lawyer. It -- I can talk about expectations, what -- what payers paid, what they were agreed to pay, what that implies their understandings were, but the liability seems to be something up to you gentlemen.

Q. All right. Now, I do want to move to Connecticut for just one second.

MR. HEROLD: And I want to mark as the next exhibit your declaration, which is dated January 19th, 2006, and which I note for the record was not served on the Defendants until, I believe, February 13th of 2006.

(Declaration, 2/13/06 marked Exhibit Hartman 055.)

Q. Now, Doctor Hartman, am I correct that in the exhibit I've just given you, Exhibit Hartman 055, that is the first time that you expressed an opinion as to the amount of damages for each Defendant involved in the Connecticut case?

MR. NALVEN: Objection.

1247

A. I guess I would frame it that in the November expert disclosure I disclosed the -- the methodology that I would use to calculate damages. I'm trying to remember whether there was any -- any effort to do any interim calculations or preliminary calculations, since we were still getting some data, for that matter.

But this is certainly the first time that the -- data that we did receive -- some of which we received in December, and I think we had the final stipulation as to the -- your data as of October 31st, that we -- that I can use that data and -- and build it into -- into the calculations for -- for all the Defendants in as best way as I can -- could -- given the understanding of the data.

Q. All right. In this Exhibit Hartman 055, your Connecticut declaration, did you express an economic expectations opinion with respect to the Medicare copay parts of the case? And I'll refer you, just to refresh your recollection, to Paragraph 12.

1248

MR. NALVEN: Objection.

A. Again, subject to the same caveats that we talked about before, about what -- what is a reading of liability or whether that's my determination to make, I do use -- for the -- the Connecticut supplemental Medicare coverage -- the 30-percent yardstick that we've spent our time discussing in the MDL matter.

Q. And am I correct that you used that, at least in this report, both with respect to Connecticut consumers who make their own copayments under Medicare, as well as situations where Connecticut Medicaid makes a copayment for Medicare?

MR. NALVEN: Objection.

A. That's correct.

Q. Now, Doctor Hartman, in this same report do you express an opinion based on your economic expectations theory -- the 30-percent yardstick theory -- with respect to payments made by any Connecticut state program? That is, Connecticut Medicaid or any of the other state Connecticut

1249

programs?

MR. NALVEN: Objection.

A. For the state Medicaid programs or any of the -- the state programs, the medical assistance programs, I look to the statutory language in the statutes for the -- the definition of damages, without doing any kind of yardstick analysis for those drugs.

Q. So, you don't do your 30-percent yardstick analysis for the Connecticut program -- Medicaid program drugs.

A. That's correct.

Q. All right. And I'd like to refer you now to Paragraph 11 of this same exhibit where you state sort of in the middle, "I have been directed by counsel to assume a finding of causation and liability if actual reimbursement related to AWP exceeds the ASP." Did I read that correctly?

A. You did.

Q. And so, am I correct that, with respect to the -- you call it Connecticut MAP or Connecticut Medical Assistance Program portion of

1250

the Connecticut case, you were directed by counsel to assume a finding of liability if the actual reimbursement exceeded the ASP, is that right?
A. That's correct, with the proviso that I was asked to also review the statutory language to see if it was in that -- if it fit -- if that -- what I was directed to assume fit within that language. But I was directed to assume that.
Q. And am I correct that -- I believe you testified to this already but I just want to make sure -- that you are not rendering an expert opinion on interpretation of statutory language in this case, is that correct?
MR. NALVEN: Objection.
A. That's correct. That's correct.
Q. Now, Doctor Hartman, I want to ask you some questions.
A. I'm sorry. I'm sorry to interrupt. I was -- had a --
THE WITNESS: Can I hear that question back again of what --
(Question read back.)

1251

A. And you mean expert legal opinion or -- or an economic interpretation of -- of statute? I mean, this is where I realize that there may be a little more nuance to the question. Certainly, as I -- we've just been talked about -- talking about the reading of -- of what -- of Paragraph 11 and what I was asked to assume by counsel, I did cite in Paragraph 13 some of the statutory language, and I do render some opinion of how an economist would interpret those terms. So, just to make sure that I've been fully responsive to that question, I do look at that and see what it -- what it says and see whether it corroborates what I've been asked to assume.
Q. All right. So, I -- we've covered this before --
A. Okay.
Q. -- so I don't want to go back over it.
A. Okay.
Q. I'd like to ask you some questions relating to how the world would work if the alternative liability yardsticks that you used in

1252

your second report in the MDL for Medicare and in your Connecticut report for Medicaid, how the world would work if those alternative yardsticks were applied. And to do that, I've prepared a -- a brief document that I want to hand to you to help us get through this discussion, which I'd like to mark as the next exhibit.
A. Is this a pop quiz?
("Hypothetical" marked Exhibit Hartman 056.)
Q. Doctor Hartman, I've handed you what I believe has been marked as Exhibit Hartman 056. It's a document that I've prepared to help us explore this area in the deposition containing a hypothetical, and I just want to go over that with you --
A. Okay.
Q. -- to make sure we're on the same page.
MR. NALVEN: Just note my objection to the exhibit.
MR. HEROLD: All right.
Q. The hypothetical posit that the AWP for

1253

a drug is 100 and that the ASP for the drug is 80. Am I correct that under that hypothetical in the way you look at spreads there would be a 25 percent spread?
A. That is correct.
Q. All right. And am I also --
MR. NALVEN: Excuse me. Can we give Doctor Hartman a moment to look at the entire document --
MR. HEROLD: Sure.
MR. NALVEN: -- before you question him?
MR. HEROLD: Sure.
MR. NALVEN: Thank you.
A. (Witness reviews document.) Well, perhaps I'll defer looking at the document in total. Let's see how it evolves and -- and see where we go from there.
Q. That's fine. So, am I correct that the 25 percent spread presented by this hypothetical is within your less-than-30-percent-spread-expectations yardstick?
A. That's correct.

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Q. All right. Am I correct that under your December MDL report there would be no liability to either third-party payer class or either of the Medicare classes with this hypothetical spread?
A. Well, it's my understanding that's for the court or the jury to decide. It certainly is less than the -- the expectations that I have found, and we can say that -- that much.
Q. Well, let me put it another way: Does it meet your liability threshold?
A. It does not exceed my liability threshold.
Q. Or the 30 percent speed limit -- 30-mile-an-hour speed limit we've been talking about?
A. That's correct.
Q. All right. And one of the things that I tried to figure out based on your testimony is you said -- you've said that the AWP sends a signal to the market about what the ASP should be, is that correct?
A. It is a list price that indicates what transactions prices would be or signals what

1255

transactions prices would be.
Q. All right. And again, I tried to do the math, but if the AWP is a hundred and you allow for a 30-percent spread between ASP and AWP, I believe, under your methodology, the signal that would be sent by an AWP of a hundred would be that the ASP would be no lower than 76.9. Why don't you take a minute and tell me if that's correct.
THE WITNESS: Does someone have a calculator?
MR. KAUFMAN: Just on my Blackberry. You're supposed to go ahead and do this in your head.
THE WITNESS: No, I can't balance my checkbook. I always use a calculator.
MS. NEMIROW: Here you go.
THE WITNESS: Thank you.
A. (Performs calculation.) That is correct.
Q. All right. And am I correct that the -- under your expectations yardstick approach, an AWP of a hundred would send the same signal to all

1256

payers that the ASP should be no lower than 76.9?
A. No. Remember, what I've said is this is the lower bound of the expectations of all payers. There's going to be a range. Some people may look at that AWP and think, oh, you know, the ASP might be 80, 84. There's -- there's ranges of what this -- what this is and how -- how informed various payers may be. But it's saying that within the information that was available and what was reflected in contracts and what was reflected in the way manufacturers priced drugs where they didn't need to compete on spread, that that spread would not exceed 30 percent. And so, the ASP would not be lower than 76.9, not that everybody's going to know that.
Q. All right.
A. But --
Q. Fair enough. But all payer types, generally, would get the same signal, is that correct?
A. The -- I think what -- if we go back to the Figure 1-A through 1-C in my declaration, it

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shows that there -- when there's a -- an AWP and an ASP, and there are -- there's a spread, what you're finding is various people are on that frequency distribution around the discounts off of AWP, and so, that's what you find characterizing all payers. You know, it's -- it's that distribution.
Q. Okay. Just one quick digression. I believe you testified earlier today that it's your understanding that the commercial publishing services such as First Data Bank and Redbook published a -- an AWP and a WAC, typically, for drugs, is that correct?
MR. NALVEN: Objection.
A. The -- an AWP is produced by both price-reporting services. It is my understanding that some companies report an AWP and a WAC. Some report just a WAC, and that there's an understood formula of how much that -- what the set markup is by manufacturer. So that, in essence, by manufacturer it may not -- WAC may not be reported. AWP is reported, and WAC may be

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reported. I'm not sure about whether WAC's reported for all drugs.
Q. All right. Well, do you have an understanding that GSK reports a WAC?
A. I would assume GSK reports enough information such that a WAC and an AWP are available.
Q. Right. And I'm focusing now not so much on what the company reports, but on what is published publicly in the commercial reporting services. And what I'm trying to get at is, as you testified this morning with respect to Remicade, am I correct or is it your understanding that both an AWP and a WAC are typically reported by both First Data Bank and Redbook and the other commercial reporting services?
MR. NALVEN: Objection.
A. I'd -- it seems asked and answered, but I -- AWP is reported. WAC can be reported. I'm just not sure whether WAC is reported for 90 percent of the drug -- WAC for 95 percent of the drugs or 75 percent of the drugs, and I would have

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to go back and check whether for GSK they report both, but they certainly report both for lots of companies and lots of drugs.
Q. All right. And I believe you also testified earlier that there's typically a relationship between WAC and AWP of anywhere between 20 and 25 percent with some exceptions, is that right?
MR. NALVEN: Objection.
A. Of ASP above WAC, that's right, or some express it at 16, 21 percent of WAC below AWP, but, yes, of the spread relative to WAC, it generally has been 20 to 25 percent.
Q. I think you misspoke. I think you said ASP and WAC. I think what you meant was as between WAC and AWP?
A. Yeah, if I said it, I'm sorry. I -- yeah I meant between AWP and WAC, WAC is -- AWP is generally 20 to 25 percent above WAC or some people say, Well, WAC is 16 to 21 percent below AWP, it depends on -- it's the same calculation.
Q. All right.

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A. Same relationship.
Q. All right. Now, returning to the hypothetical, I want to look at how your various liability opinions impact a hypothetical --
A. Can I destaple this?
Q. Yes, you can -- if you don't follow the 30-percent yardstick consistently, and that's what the second page is designed to help us talk through. And just for the record, on the second page of this document, Exhibit Hartman 056, we're sticking with the same ASP of 80 and AWP of a hundred. Do you see that?
A. I do.
Q. And I just want to understand the result under your alternative yardsticks with respect to liability with that same set of assumptions about ASP and AWP. And am I correct that under all of the reports that you've written, if the ASP is 80 and the AWP is a hundred, there would be no liability to the third-party payer class, is that correct?
MR. NALVEN: Objection.

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A. I'm -- okay. Let's -- so, we're -- I was starting to think ahead. So, could you start again. I'm sorry.
Q. Yeah. Am I correct that if the ASP is 80 and the AWP is a hundred that you've consistently taken the position in all of your reports that there would be no liability to the third-party payers -- the private third-party payers -- because you consistently stick with your 30-percent yardstick for that type of payer, is that correct?
MR. NALVEN: Objection.
A. As I -- as I said, I've -- in terms of being asked to do the calculations for damages, under all of the different analyses that I've put forward, it has been the case that I've -- I've been asked to use the -- the 30-percent yardstick for expectations for nonMedicare reimbursement. That -- that's correct.
Q. All right. Now, when you say you've been asked to use a 30-percent yardstick, isn't it your opinion as an economist in this case that the

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30-percent yardstick is the appropriate yardstick to use for this market to estimate third-party payer expectation?
A. It is my opinion, as laid out in great detail, that -- that a 30-percent yardstick represents a reasonable up -- upper bound of what was understood in the market of that relationship between AWP and transactions prices for the market as a whole. And what that implies for liability seems to be a legal issue under different statutes, but that will -- I take it that far.
So, I mean, I've described it as expectations and exceeding what was -- what was understood and reflected in pricing and contracts.
Q. All right. And am I correct that with respect to your alternative yardsticks that were expressed first in the MDL -- well, that were expressed in the MDL in your second report for Medicare, and were also expressed --
A. Let's -- let's stay there. I can't keep all of these hypotheticals in my mind. So, let's -- so, we're in the MDL.

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Q. Right.
A. Okay. And now you're saying I'm now being asked to look at the world where the -- for Medicare I'm not evaluating damages subject to that 30-percent threshold. I just do it subject to the statute.
Q. The world I'm trying to get you into is the world that you opined about in your second MDL report --
A. Right.
Q. -- in February of 2006 --
A. Uh-huh.
Q. -- in which you took the position, as I understand it, that for the Medicare classes you would not apply the 30-percent yardstick either for liability or damages as requested by counsel?
MR. NALVEN: Objection.
Q. Are we in the same world?
A. We are in the same world.
Q. All right. And am I correct that if we're in that world, under this hypothetical where the ASP is 80 and the AWP is 100, there would be a

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finding of liability?
MR. NALVEN: Objection.
A. There would be -- in this world, there would be damages assessed to reimbursements under Medicare.
Q. When you say damages would be assessed, am I not correct that in your second report, as compared to your first one, you swept in a number of additional drugs for most, if not all, of the Defendants for the Medicare part of the case by applying a different liability threshold of zero, as opposed to a liability threshold of a 30-percent spread?
MR. NALVEN: Objection.
A. Certainly when -- I do not exclude drugs based on a 30-percent threshold. More drugs will be subject to a damage calculation as they were in the supplemental report.
Q. All right. So, to use your words then, under this hypothetical where the ASP is 80 and the AWP is a hundred, in your second MDL report you would find that there would be damages to the

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Medicare classes, even though the ASP is within the expectations of Medicare payers, is that correct?
MR. NALVEN: Objection.
A. There are damages assessed, even though that threshold is not exceeded, which means that the relationship -- there are damages assessed even when that -- the spread is -- does not exceed what people expected it to be.
Q. All right. And am I correct that you applied that same liability threshold in your supplemental declaration in Connecticut, dated February 9th, 2006, with respect to the Medicare portions of the Connecticut case?
MR. NALVEN: Objection.
A. In the supplemental to the -- that's correct.
MR. HEROLD: All right. And just for the record, I want to mark that.
("Calculation of Damages to Connecticut" marked Exhibit Hartman 057.)
Q. And looking at your supplemental

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Connecticut report, which is dated February 9, 2006, if you look at Paragraph 1-B on the first page, am I correct that that reflects your change in your liability threshold for the Medicare parts of the case from applying a 30-percent spread yardstick to a zero-spread yardstick?

MR. NALVEN: Objection.

A. Well, it's -- it's -- I would characterize it the way I characterize it there, and that I -- it's -- that I -- that I don't use the 30 percent, but that the Medicare statute regarding reimbursement were binding and --

Q. Okay. Now, turning for a second to your opinions with respect to the Connecticut Medicaid program and other Connecticut public health programs, am I correct that under the hypothetical that we've been discussing where ASP is 80 and AWP is a hundred, you would find that the liability threshold has been exceeded and there is liability?

A. Under the Medicaid reimbursements, that is correct.

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Q. All right.

A. Well, that there are -- essentially, that there are -- I've been asked to assume that for the Medicaid spending that the Medicaid -- the statutes regarding reimbursement were binding. So that as it's stated in -- just as we talked about before at Paragraph 11, that reimbursement should have been at the estimated acquisition cost or the ASP -- just to word it precisely.

Q. Well, to word it precisely, as you said in your declaration, you have been "Directed by counsel to assume a finding of causation and liability if factual reimbursement related to AWP exceeds ASP," is that correct?

A. That's correct, and if that's how -- if that's the rubric under which you want to continue to say, "liability" that that is within that sentence. It's governed by that sentence.

Q. That's what I --

A. Okay.

Q. That's what I have been trying to do.

A. Okay. Sorry.

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Q. Now, again, under Connecticut Medicaid in the opinions that you expressed, for a hypothetical where you just said that you would find liability if the ASP is 80 and the AWP is a hundred?

A. Can you help me out? Are we on -- we're back here on this page now?

Q. Yes.

A. Page 2?

Q. Yes. Let me start all over just so the record's clear.

A. Okay.

Q. With respect to Connecticut Medicaid where you have just testified that -- that you would find liability as directed if the ASP is 80 and the AWP is a hundred, am I correct that your finding of liability in that circumstance would exist, despite the fact that the spread is within the 30-percent yardstick that was expected by payers?

A. That's correct.

Q. And am I correct that you would find

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liability under that scenario for drugs that you used as "comparator drugs" in developing your 30-percent yardstick, such as Zofran before there was competition from Kytril, that you would find liability under that Connecticut Medicaid scenario, even for those comparator drugs, is that correct?

A. The measures of the damages that we'd have to look at really are driven a little bit more by not just the AWP, but if you will look at Paragraphs 13 through 16, you'll notice that in, let's say, Paragraph 13-C, the third bullet on Page 6, that there were certain periods of time when the estimate of the estimated acquisition cost was AWP minus 40 percent for certain generics. And there was -- well, it was 12 percent for branded.

So that there were certain cases here where it -- the -- the damages would have -- there would have been no damages, even at spreads larger than the yardstick, based on these types of calculations. But for the -- for the most part,

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subject to the caveat that the actual calculations were determined a little more closely by -- it wasn't just AWP minus ASP, but it was a proportion of -- I know it's 92 percent, 88 percent, 60 percent of AWP. That's certainly the case for when it was 60 percent of AWP that would -- there would be no damages if -- at -- in excess of the 30-percent spread.

Q. All right. Let -- let me go back to what I was trying to ask you.

A. Okay.

Q. You testified yesterday, am I correct, that you looked at drugs including Zofran that had no therapeutic competition at the time when Zofran was first launched, and you looked at those drugs which you called comparator drugs to help frame a reference for your 30 percent liability yardstick, is that correct?

A. That's right.

Q. And that you took the position in looking at those drugs that the market would expect the kinds of spreads you see on a brand

1271

name innovator drug shortly after launch, correct?

A. That's right.

Q. And that Zofran was one of those comparator drugs.

A. Right.

Q. And then for that drug, therefore, on your expectations theory in your December 15th report, you would find no liability, correct?

A. That's right.

Q. All right. Now, I want to turn your attention to Exhibit Hartman 057, the supplemental declaration in Connecticut. One more question before I direct you to a page. Do you have an understanding that Zofran had a market monopoly and was the kind of comparator drug that you selected in the year 1993?

A. It's my understanding, and let me enrich that understanding just by --

MR. NALVEN: You just want to ask him to assume that, Fred?

A. Do you want me to assume? I mean, I -- I wanted to look as what the spreads were and how

1272

they compared to Kytril. I mean, if we're getting to a date when Kytril launched and when spread competition occurred --

Q. Well, I can tell you -- ask you to assume that Kytril was not launched until sometime in 1994.

A. Okay. Let's -- we'll keep going and see.

Q. All right. So, on the assumption which I represent is a fact that in 1993 Zofran had no direct therapeutic competition and that you have, in fact, stated in your earlier affidavit that Zofran was a comparator drug for that time period, now I want to direct you to portions of the supplemental Connecticut report in which you made determinations with respect to whether there should be liability or damages for Zofran.

And in particular I want to -- want to direct you to the -- Page 19. It's the second-to-last page entitled "Table 3-C Medicare Copay Damages -- Consumers." Do you see that?

A. I do.

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Q. And am I correct that you are expressing an opinion in this particular document that for the year 1993 when Zofran was a comparator drug with no therapeutic competition, you are still finding liability and damages, is that right?

MR. NALVEN: Objection.

A. Subject to -- to the sentence in Equation 11, that's correct.

Q. Do you see anything inconsistent between selecting Zofran as a comparator drug for your yardstick and market expectations analysis and yet at the same time rendering an opinion that GSK is liable for damages for the spreads on Zofran during that same period?

MR. NALVEN: Objection.

A. It -- it seems like that's a legal question that -- I mean, I've framed my understanding and my use of Zofran in the ways that I have and how an economist would use those and draw conclusions therefrom. The extent to which statutes require reimbursement in one form or another is something -- whether the legal

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issues trump the economic issues or -- I can only offer an economic opinion.
Q. All right. Now, I want to take you back to the hypothetical, and the last portion of it on Page 2 asks you to consider what would happen in the market if your alternative liability standards were applied. And we start with the assumption in the hypothetical that the ASP for the drug is 80. Do you see that?
A. I do.
Q. And am I correct that under your method of analysis, the ASP is 80, then, at least with respect to third-party payers, publishing an AWP of 100 would not subject the manufacturer to liability, is that correct?
A. That's correct.
MR. NALVEN: Note my objection.
A. Under -- under -- yeah, under the hypothetical.
Q. All right. And however, under your alternative theory for Medicare in which you find damages and assume liability, if the AWP -- if the

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ASP and the AWP are not within 5 percent of each other, am I correct that if the ASP is 80 for a drug, and you publish an AWP of a hundred, there would be liability, is that right?
A. To the extent that the AWP or a -- the percentage off of AWP -- 95 percent or 85 percent -- we're talking about -- now about Medicare -- we're in the MDL world now?
Q. Well, we're in the world where you are expressing an alternative opinion as directed that for Medicare there is liability if the ASP and the AWP aren't within 5 percent of each other.
MR. NALVEN: Just note my objection to the continuing use of the word "opinion" in connection with these reports. Doctor Hartman made clear that these are calculations that were performed at the direction of counsel.
A. Yes. I mean, again, all of this is under the -- the instructions we've identified in that sentence in Paragraph 11 in that your -- you use the notion of my notion of liability. I've -- that's, again, for what I think the court is going

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determine here.
You know, I've talked about economic descriptions here, but it is certainly the case that, as a matter of economics and what the AWP signals, that, given an ASP of 80, that a list price of a hundred, an AWP of a hundred would not be a signal that would -- would lead to some kind of fraudulent manipulation of -- of expectations.
However, if there were a drug of that sort and yet, under the Medicare statutes Medicare was to reimburse at the -- what is written into the regulations -- at AWP or 95 percent of AWP or the lesser of that, an ASP, then that drug that falls within those expectations would still be subject to damages under the calculations that I've done and that I've been asked to do.
Q. All right. And I'm trying to get at what a manufacturer -- a manufacturer would do in the real world, given the liability framework that your counsel has asked you to assume, and I appreciate the clarification for Medicare. If the ASP was 80 and it wanted to publish an AWP that

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would not subject it to liability, what would the AWP have to be?
A. The AWP, in order for a -- for a manufacturer to avoid exceeding the expectations that I've found governed -- in just all the ways we've talked about -- just insert here the tape of those discussions -- the AWP of a hundred -- if they posted that of a hundred -- would not exceed those expectations.
And whether that is subject to liability under the -- my December report or whether that makes Medicare reimbursement subject to liability under the alternative assumptions is something that I -- I don't have an opinion about. That's something that I understand is an issue that is a legal and regulatory issue.
Q. All right. But what I'm trying to get at is I'm trying to get at your opinion as an economist or somebody who understands this market about what a manufacturer would do if your counsel's version of alternative liability is adopted in -- in terms of trying to figure out

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with an ASP of 80 what AWP it should publish to avoid liability under those -- those alternative theories for Medicare.

A. You know, I just haven't been asked to do that kind of analysis. And if I were asked to do it, I'd direct -- as directed and how it needs to fit into legal interpretations -- I'd -- I would need -- I would do that, but I haven't been asked to do that. And so, I wouldn't -- I'd just be speculating now and speculating on a mix of economics and the law, and that would need to be something that would be done -- I would want to do more carefully, and it's something that I could do in a rebuttal stage, if -- if I'm asked to and --

Q. Well, isn't this a matter of simple mathematics? If -- assuming the liability standard, as you state, for Medicare is that ASP has to be no less than 95 percent of AWP. If you know what the ASP is and it's 80, can't you simply calculate what the AWP would have to be to avoid liability under that standard? And I've tried to do it here in this hypothetical, and, according to

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my math, in order to get an ASP of 80, the AWP would have to be no higher than 84.2. Have I done my math right?

A. I will assume that you have done your math right. However, I'm not suggesting or drawing an economic conclusion that, based on the fact that calculations of damages have been done in the way that I've asked that they be done, that that would change the way -- the market has used the list price of AWP and it's reflected transactions prices that have reflected a history of -- of these markets for the last 30 years or so. And it certainly culminated in reimbursement contracts and reimbursement rates and statutory language that was reflected in the -- at the beginning of this damage period.

The -- if you're asking me as an economist should -- in order to avoid that particular calculation of damages, the whole notion of the industry and reporting should change, I'm not ready to render that -- that opinion, and that would need to be something that

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you're -- you're talking about a counterfactual world that runs against the way this industry has worked for the last 30 years, and I -- and it's something that may be entertaining to reflect upon, but I'd need to -- to give an expert opinion, I'd need to do more than just do that calculation.

Q. Am I correct that for the last 30 years, manufacturers -- for -- for manufacturers' drugs, the reporting services had reported a single AWP for each NDC, is that right?

A. There have been --

MR. NALVEN: Objection.

A. -- there have been AWPs reported -- the Redbook will report an AWP for -- for the NDCs of -- of drugs, and as it received information from manufacturers, it will change that. First Data Bank also posts an AWP for drugs. In some cases, given the calculations, the AWP might be slightly different, but they're very close, and -- and different -- different entities look to one source or the other, but it's still within the range of

1281

the expectations and the calculations that I've done, and I've made that clear in my description of the comparator drugs.

Q. Okay. I appreciate the clarification and my question wasn't precise enough --

A. Okay.

Q. -- so let me try to ask a better question. My question is, if you take a single reporting service, let's say First Data Bank, and I take a single point in time, am I correct that for that reporting service for that point in time there is only one AWP reported for each NDC, not multiple AWPs for different markets?

A. That -- that's correct.

Q. All right. Now, am I correct that if the 30-percent-yardstick view that you express in your December 15th report, which you have repeatedly said would apply to different types of payers, if that were adopted as a liability standard, then you wouldn't have this issue or problem of the manufacturers having to post different AWPs depending on which payer we're

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dealing with, is that right?
A. Well, I don't think -- it's certainly not my testimony or my opinion that the manufacturers should or did post different AWPs. I'm -- it's my opinion that an AWP is a list price, and it's been understood to be a list price, and as a matter of any -- any market structure, legally can be a list price that's a signal for transactions prices. And so, I've not proposed that, nor entertained that, nor recommend that, nor been asked to analyze that there should be some different way of posting AWPs for different types of payers.
Q. All right. Turning back again to Connecticut, with respect to your opinions expressed in both Exhibits that we've been looking at with respect to Connecticut Medicaid and medical assistance programs --
MR. NALVEN: Objection.
Q. -- did you undertake any effort to determine liability or calculate damages using your 30-percent expectations yardstick for that --

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MR. NALVEN: Objection.
Q. -- type of payer?
A. For the Medicaid portion of it and for the programs under the Medical Assistance Program, no.
Q. Why not?
A. I wasn't asked to.
Q. Could you -- could you do that?
A. The -- one could do that, but if -- if you recall from my -- and I'm sure it's emblazoned in your memory -- from my affirmative declaration on class, the variations of AWP and how the signals work for self-administered drugs may differ from physician-administered drugs. So, one would have to think about what those signals were in that context, whether they were the same, whether they -- I've developed yardsticks for expectations for physician-administered drugs. So, one could -- one could do that kind of analysis, but that was, given the Court's opinion, I -- I did not pursue that analysis. So, that is something that is subject to economic analysis.

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Q. All right. Am I correct that with respect to GSK, the Connecticut case involves physician-administered drugs, including, in particular, Kytril and Zofran?
A. You are correct.
MR. HEROLD: In fact, just so the record's clear, we'll mark the Connecticut complaint as the next exhibit.
(Revised Complaint, 3/5/04 marked Exhibit Hartman 058.)
MS. WITT: Fred, so the record is clear, which complaint is that?
MR. HEROLD: This is the State of Connecticut versus GSK.
MR. NALVEN: The revised complaint dated March 5th, 2004.
MR. HEROLD: Correct. Thank you, revised complaint.
Q. Do you have that in front of you --
A. I do.
Q. -- Doctor Hartman? Now, if you'll turn to Page 28, the table.

1285

A. I have done so.
Q. You see there listed the drugs Ventolin, Zofran, Navelbine, Kytril and Hycamtin, is that correct?
A. It is correct.
Q. And is it your understanding that those are the drugs for GSK that are subject to the claims in the Connecticut case?
A. It is my understanding those were the drugs -- well, it's -- it's clear that those are the drugs included in the complaint. The subset of drugs that -- that I was asked to look at seems to be a smaller subset than that. And there -- there may have been other revised -- as I read that revised complaint, those are the drugs listed.
I see that in my actual damage analysis I only focused on Kytril and Zofran. So, I would have done that at direction of counsel, I would -- I would guess. So, yes, that's what I see in this table. Whether that -- whether this is the final word on it, I know I've seen a variety of

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complaints and evolution of -- but given that this is the final revised complaint and these are the drugs that are listed, then that would seem to be the case.

Q. All right. So, am I correct, as you just pointed out, that as of this date you have not rendered any opinion as to liability or damages for Ventolin, Navelbine, and Hycamtin?

MR. NALVEN: Objection.

A. That's correct.

Q. And so --

MR. NALVEN: When you say, "rendered an opinion," what do you mean?

Q. I mean have not provided any expert opinion in any report or otherwise in the Connecticut case with respect to liability or damages for Ventolin, Hycamtin, and Navelbine, is that correct?

A. Well, I guess the way -- the way I'd answer that is, in my expert disclosure I put forward methods that could be used for all those drugs, and as it came time to finalize the -- the

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drugs that were to be included, they did not include those drugs. The formulaic methodology was designed to include any -- any drugs of GSK that I would have been asked to do. But in -- as this -- the timing of this particular disclosure was reaching maturity, those were the drugs I was asked to -- to look at and did not include a detailed analysis of -- or any analysis of the other drugs.

Q. All right. So, stated another way, in the Connecticut case, you have rendered opinions as to liability and damages only with respect to Kytril and Zofran, is that correct, for GSK?

MR. NALVEN: Objection.

A. The -- it's -- my report stands as it stands, and it only includes those drugs for GSK.

Q. And am I correct that both Zofran and Kytril, in their injectable forms, are physician-administered drugs?

A. That's correct.

Q. So, I want to go back to my prior question, which is, why didn't you provide an

1288

analysis that showed the application of your 30-percent yardstick to Kytril and Zofran, both physician-administered drugs, in the Connecticut case?

A. You are asking whether in the damages calculated for the Connecticut programs that included the physician -- that -- not -- not the -- the Medicare copay part of the analysis, but you're talking about what was part of the MAP analysis and the drugs that were reimbursed under -- under that program.

Q. That's correct.

A. And that was, again, subject to that sentence in Paragraph 11.

Q. That is at the direction of counsel?

A. Direction of counsel, that's correct.

Q. And I want to again ask my other question, which I tried to ask before, which is, could you, as you sit here today, conduct an analysis of how the 30-percent yardstick would affect liability and damages for Kytril and Zofran for the Connecticut Medicaid programs?

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A. I could -- I could do a supplemental analysis of -- of expenditures under the medical assistance programs of Connecticut for those drugs with -- with that 30-percent threshold if I were asked to do so.

Q. Now, I want to turn for a second to your first declaration in the MDL, and I have an excerpt from it which I'll give you just to make, hopefully, it easier.

(Attachment I.3: GlaxoSmithKline Drugs Subject to Liability" marked Exhibit Hartman 059.)

Q. Doctor Hartman, for the record, I've handed you what's been marked as Exhibit Hartman 059, which I will represent is an excerpt of two pages taken from your first liability report in the MDL, and they were Attachment I.3 entitled "GlaxoSmithKline Drugs Subject to Liability," and Attachment J.3.A entitled "GlaxoSmithKline Medicare Damages Beneficiary Subclass 1 by NDC." Do you have that?

A. I do.

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Q. And focusing now on Attachment I.3, the first page of Exhibit Hartman 059, am I correct that that is a chart that was prepared under your direction which contains an X for each instance under which you found in your December 15th report GlaxoSmithKline drugs were subject to liability?
A. That they exceeded the 30-percent threshold, that's correct.
Q. So, am I also correct that if there is no X for a given NDC in a given year on this same attachment, then it would be your opinion under the December 15th report that there would be no liability with respect to that NDC in that year, is that correct?
A. Subject to the caveat that I would need to check our coverage of data and whether or not, indeed, we had data -- I see Xs in 2003. Now, I'm assuming the data production from GSK was -- was a complicated one, and there were lots of files, and I'd need to confirm whether we have -- we had comparable data through 2003 for all the drugs, but certainly for those years, yeah, if we had the

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data and there's not an X, then that -- that's true.
Q. All right. I notice in here that you do not have any entries for the year 2004, is that correct?
A. That is correct.
Q. And why is that?
A. Turning to the attachments to my December 15th declaration, in particular Attachment G.3.A, it lists the ASPs that we were able to calculate for the Glaxo drugs for the period of time for which we were able to do so. And so, you will notice that -- and this is why I was talking about the concern about say 2003 for -- for Alkeran, my examination of G.3.A tells me we did not have sufficient data to calculate the ASPs, and hence the spreads, that would allow me to do that analysis for that year or else you no longer offered the drug that year, and I'm trying to see here in the summary of the -- the Glaxo data provided to us that it says on Page 1 of G.3.D, "Description of Electronic Data" that

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"Note: In general, data are available for all drugs from '97 to 2002. Note: In addition, to the extent that the drugs existed, data are available for Kytril, Ventolin, and Zofran, 1993 through 2003." So, we didn't receive data for 2004, and we didn't receive data for -- for a number of drugs prior to '97, and we didn't receive data for a number of drugs post '92 -- 2002. I'm sorry.
So that would -- if we couldn't make a finding, we -- we didn't make a finding.
Q. All right. And am I correct that you did not make an attempt to extrapolate for years for which you had no data?
A. We did make attempts to extrapolate if -- once we calculated damages, if we saw patterns of damages that were -- we did -- we could have extrapolated and interpolated in a variety of contexts, but it is my recollection, and we can go back and look more specifically, if there were a pattern of damages -- whoops. Let me keep all this together. (Witness reviews document.) Well,

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let me just -- rather than -- if we want to go look at it, we can look at it -- time being of the essence. There -- once damages were calculated, if I noted -- there were -- and it's described in detail -- the extrapolation methods and decisions that were made so that your experts can thoroughly vet those.
Say for the Alkeran IV, the 50 milligrams, if there were damages over a period of time of five years where there was a -- whatever that pattern was, I would either take averages or, if they were going to zero, I'd leave them at zero. I would look at the pattern of what was implied at the final stage of -- of the calculations, rather than at each of the individual interim points.
Q. All right. And am I correct that your opinion, subject to these data limitations and including any extrapolations that you did with respect to whether there are -- there's liability and damages for the GSK drugs in the MDL is -- are -- with respect to Medicare, I'm sorry -- are

1294

summarized in the exhibit that we've marked as Exhibit Hartman 059? Is that a fair description of Exhibit Hartman 059?
A. Subject to the 30-percent threshold and subject to those -- the caveats regarding the data, that's correct --
Q. All right.
A. -- for the Medicare beneficiary -- for Subclass 1.
Q. Right.
A. Yeah.
Q. Now, if I could ask you just for a second to take a look at the -- your second report in the MDL, and I want to refer you to your calculations of alternative damages in Attachment A.3.A.
A. Now, will it pay for me to leave some of this open and compare or not? Am I -- are we going to do -- do I want to leave this, or do I want to fold this up?
Q. I think you can fold that up.
A. Okay. Okay. And you were saying to --

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you had the --
Q. It's Attachment A.3.A, which is entitled -- this is under your alternative liability standards --
A. Right.
Q. -- entitled "GlaxoSmithKline Medicare Damages Beneficiaries Subclass 1 by NDC." Do you have that?
A. Right, I do.
Q. And I just have a couple of questions on this document. If you look at Ventolin, the first entry, "Ventolin Solution Inhaler," do you see that?
A. I do.
Q. Do you see that -- in fact, for both Ventolin formulations, am I correct that you do not have any damage numbers for the year 2001, 2002, 2003, is that right?
A. At this stage of the analysis, I do not. That's correct. But give me just a -- well -- okay. Go ahead with your question.
Q. Is it your understanding that Ventolin

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is a multi-source drug?
A. Given the number of drugs that are in this -- in the class -- I have to go back and check my notes whether it is or not. I can't recall.
Q. If I represent to you that Ventolin is Albuterol sulfate, will that help you determine whether that's a multi-source drug?
A. That would help me, yes.
Q. And what would the answer be?
A. The answer would be yes, if -- subject to that.
MR. HEROLD: David, I have about 15 minutes with another area, and then I'll be done with the MDL completely, all right? Are you okay to go for another 15 minutes or so?
THE WITNESS: I may have to visit a men's room for two minutes.
MR. NALVEN: Well, then let's take a two-minute break.
MR. HEROLD: You want to, that's fine.
MR. NALVEN: Let's take a two-minute

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break.
MR. HEROLD: Okay.
VIDEO OPERATOR: The time is 12:35. We're off the record.
(Recess was taken.)
VIDEO OPERATOR: The time is 12:39. We're back on the record.
Q. Doctor Hartman, before we move into a different area, it's been pointed out to me that there is an error in Exhibit Hartman 056, the hypothetical. And I think it's inconsistent with your testimony, and I want to make sure we straighten that out. Do you have that in front of you?
A. Okay.
Q. If you'd turn to the second page, at the top where we're talking about results under your alternative yardsticks, do you see where it says, "If the ASP is 80, the AWP is a hundred, there would be liability to the Medicare classes because ASP is greater than Medicare reimbursement rate." Am I correct that that ought to be less than not

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greater?
A. You are correct.
Q. Could you just take a pen and fix that and make that less than.
A. How embarrassing.
Q. For me.
A. I know.
Q. And then on the one right after that where it says, "Liability for Connecticut Medicaid because ASP is greater than published Connecticut reimbursement rate for PADs," that should be less than, too, right?
A. I see that, yes.
Q. Does it now accurately reflect your testimony?
A. It does -- it's more accurate now, yes.
MR. NALVEN: Plaintiffs move for a default judgment.
MR. HEROLD: Some of us can admit our mistakes.
Q. With respect to your method of calculating damages in the MDL --

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A. So I can put the state --
Q. For now.
A. No. No. No, I mean just for -- you opened that one page up. I can fold that up.
Q. Okay.
A. Okay.
Q. I want to ask you some questions about various aspects of your damage calculation, some of which are relatively technical, but I'll try to get through it quickly. First, am I correct that you changed your method of calculating ASP in your alternative calculations as presented in your reports?
A. If we could refer to this as my December 15th and the supplemental report, it's easier, then I know we're on the same page. The -- the calculation of ASP in the supplemental report is different, yes.
Q. All right. And are you expressing an opinion as to which of the two methods that you used to calculate ASP, i.e., that in your original report where you did not include hospitals in an

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effort to calculate ASP, and that in your supplemental report in which you did include hospitals? Are you expressing an opinion as to which of those two methods of calculating ASP is most appropriate for determining an ASP in the clinic physician market?
A. Well, I -- I will say that the -- the AWP is a -- as a matter of economics and as a matter of my opinion -- is a benchmark for all transactions prices. So, it's a -- it's a benchmark for the ASP of all units sold. It will be a benchmark for the units -- all units sold to the -- to nongovernmental units.
Certainly the preponderance of the ASPs calculated for sales just to providers are greater than the ASPs overall, because overall there's more hospital sales included and there's greater discounts and rebates or price offsets paid there. So, the AWP is a signal for -- for transactions prices generally.
For the notion of reimbursement rates to physicians where we're talking about their

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acquisition costs, the ASPs that I have chosen are the ones that reflect the ASPs for -- for those particular providers.
The spreads -- if calculated for the ASP generally, which the AWP is a signal for, is -- is -- would lead to larger spreads for the preponderance of -- of the -- of the drugs, the NDCs.
Q. All right. I think I heard you say that the ASPs that you calculated for the physician providers would be a more accurate reflection of acquisition costs for physician providers, and when I say, "The ASP you calculated," I mean the ones that you calculated in your December 15th report, is that correct?
A. That's correct, yes.
Q. Now, with respect to the Medicare classes and payers, as well as the Medicaid payers, am I correct that when you did your damage calculations throughout all your reports you did not provide a "credit" for the 30-percent spread?
A. In the December 15th declaration, if a

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drug did not exceed the 30 percent, they were excluded from the damage calculation entirely. So, there was that credit -- I mean, there was that -- if you want to think of it as a credit. I'm not quite sure I understand what you're saying about a credit. I mean, are you -- could you be more specific?

Q. Sure. All right. Well, let's -- let's focus on the December 15th report --

A. Right.

Q. -- for the Medicare classes, and you've already testified that -- in your December 15th report if the spread was less than 30 percent, you were done. There would be no further analysis, is that right?

A. That's right.

Q. But if -- am I correct that if the spread was more than 31 percent, i.e., -- more than 30 percent, i.e., let's say it was 31 percent, that when you calculated your damages, you calculated damages for that entire spread up to the Medicare reimbursement rate, is that right?

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A. As discussed in the strict definition of the damage calculations, if they exceeded that -- that 30-percent threshold, I turned to the Medicare regulatory language to calculate damages so that it -- if it was -- it might not have been 30 -- 30 percent, but if the -- if, in that period of time, reimbursement should have been the lesser of ASP and AWP, then I didn't take into account a 30-percent threshold. When it was 95 percent of AWP less -- or ASP or 85 percent, I took the strict statutory language for the calculation of what the implied reimbursement rates were, given that they weren't at acquisition cost.

Q. Wouldn't it be a reasonable approach to the Medicare classes in calculating damages to provide the same credit for the "expected spread" that you applied for the third-party payers?

MR. NALVEN: Objection.

A. You're asking me to -- to render a legal -- a legal opinion. I mean, I -- I understand -- the market works the way it works, and I -- and I observe pricing behavior and spreads, and I look

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to the statutes or the regulations to indicate what the implied damages are, and it doesn't call for a credit of that sort. So, I've -- I've left it only at -- at the regulations.

Q. As you interpret them.

A. As I interpret them, that's correct.

Q. Now, in the MDL, am I correct that you had to -- for purposes of your damage analysis -- allocate units of each drug to each of the three classes?

A. I did, yes.

Q. And in particular you had to come up with some method to attempt to allocate sales of a drug -- let's say Zofran -- to those sales which were reimbursed by, on the one hand, third-party payers -- private third-party payers, on the other hand, individual copayers, and on the third hand, to use a Yogi Berra expression, to Medigap insurers, is that right?

A. I -- I did have to allocate units to groups of payers.

Q. And am I correct that you -- that you

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did so, as explained in your December 15th declaration, by relying on the NAMCS survey data?

A. Once I --

MR. NALVEN: Objection.

A. Once I had excluded those sales that were not relevant to the class, as best I could, given the data that I received from Defendants, I then used the NAMCS data when they were available or information from a group -- there was a group of people at the Harvard School of Public Health in my team that gathered the NAMCS data that we could. We tried to get the IMS data and that -- and also looked to their own experience as to what some of these mixes might be. And then -- and then we looked at the Kaiser Foundation data and Eppig and Chulis. There's a variety of data that we looked at in those allocations, but NAMCS was one of the things that we relied on, that's right.

Q. All right. And with respect to the NAMCS data, am I correct that in order to determine the percentages paid for by each of the three classes in the MDL, you looked to specific

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encounters for the NDCs involved in the case?
MR. NALVEN: Objection.
A. What I looked to were -- there are drugs that are -- are included in the -- in the matter, and I looked to the NAMCS data for physician visits that involved dispensing that -- that drug. That that was listed in the NAMCS data on their reporting of those doctors' visits.
Q. All right. Did you take into account, in your efforts to allocate between payer classes, any other NAMCS data besides the specific encounter data that listed a specific drug?
A. I -- the -- the people that were close to the -- to the NAMCS data and did -- did the -- the allocations upon which I relied, and you know, I'm -- one of the things I'm -- just take a second to turn to -- not that anything ever takes a second -- but the -- the NAMCS data, and this is why I'm -- just to make sure that I fully understand this. The NAMCS data is laid out in Attachment J.7.A, and that includes -- and it's -- and it's the doctors' visits panel that we're

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talking about, and it includes the insurers and the groups that we're talking about, but it also includes other groups in terms of self-pay, Worker's Comp, Medicaid, which I did take account of and dealt with and netted out. And then I did supplemental analyses about purchases by DOD, which is Column 12 of the -- of that -- of J.7.A.
Q. Uh-huh.
A. And I did an analysis based on the -- the coverage of -- of governmental employees through private third-party payers, as laid out in J.7.B. so that the NAMCS data and the panel on the doctors' visits was the point of departure. I found as much additional information as I could to -- to better refine the NAMCS data.
It is my understanding from the team members that were supporting this work at Harvard that there were no additional NAMCS data that could help us with this.
Q. Well, let me ask you a question about your efforts to find additional data. For -- do you understand, first of all, that Kytril and

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Zofran are both antiemetics, which are used to treat nausea and vomiting associated with chemotherapy?
A. That is my understanding.
Q. All right. Am I correct that the NAMCS data includes data -- in fact, many data points on cancer encounters as a category?
A. Well, one can certainly sort the NAMCS data on a number of different -- I mean, a doctor's visit is delineated by ICD 9 codes, by a variety of disease codes, by a variety of different ways of sorting the data, and I sorted by the data relative to the drug and when it was -- when it was prescribed. So that I didn't necessarily look at the subset of cancer patients to do that. I looked at all the times that Zofran or Kytril were administered, which I would assume is generally in conjunction with a cancer treatment.
Q. Would you think it would be a reasonable check, if you will, on the approach you took to look at all cancer encounters involving

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chemotherapy and see how the payer mix breaks up for all cancer encounters in the NAMCS data?
MR. NALVEN: Objection.
A. The -- and I'm hoping that this will be something that can be done by -- by my rebuttal time. I mean, I've -- I've looked -- I've wanted to get the IMS data of this -- of the same sort to help corroborate what has been put forward here so that what I've put forward here is something that I -- I feel is reliable. But to the extent that one could run some alternative cuts of the data, that -- that might be informative. It might not be.
Q. Okay. Do you have access to the CMS data concerning actual Medicare reimbursements for drugs?
A. I -- one could get that.
Q. That's publicly available, correct?
A. That's correct.
Q. All right. Would you agree with me that in determining the percentage of units that were paid for by Medicare copayers, one approach would

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be to get the actual Medicare payment data from CMS and compare that to the total number of units?

A. The -- in order to implement any particular calculation, one needs to think carefully about the data and one needs to think about the consistency of all of the sources and -- and the -- my use of the NAMCS data, as it's done here, draws all information. So that most of these administrations of Kytril and Zofran turn out to be in conjunction with chemotherapeutic applications, that would still pop out the -- the dispensing of the Zofran and Kytril would still reveal itself.

So, starting to look at some other percentages in some different ways, there's a -- there's a number of ways of trying to come at this and trying to enrich one's estimates. I'm confident in the approach that I've done. I'm also confident that additional data and additional analysis could help. Just positing it the way you have now, I'd want to think about that and how it fit within the whole mix of the other nonMedicare

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sectors and what it was picking up and --

Q. Okay. But it's a reasonable approach to think about looking at this kind of exercise where you're trying to determine an allocation from data to look at various different data sources and think about their usefulness, and if a determination is made that they are useful, to cross-check one data source against another data source, is that correct?

MR. NALVEN: Note my objection. It's been asked and answered. The breadth of the term "reasonable" depends on the context in the assignment, etcetera.

A. Given world enough and time, any quantitative economist would like to look at all data available and come at it from every direction. And so, additional data is never a -- well, no, sometimes additional data can be a bad thing. One has to review, you know, one could tell me to look at something crazy, too. You know, I'd have to evaluate what -- what it might be and whether it was sufficiently helpful.

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This was -- this is certainly a -- this is certainly data used as I'm using it that's used in the scientific literature and is used -- is one of the most frequently used databases, and one can always do better with different surveys and to -- or, you know, one component, but it has to see how it fits within everything else, and I think the IMS data will be helpful to get --

Q. Okay. Did you undertake any effort in using the NAMCS data to determine whether the encounters for the GSK drugs, which include more than Kytril and Zofran, whether there were a sufficient number of such encounters to make statistically significant extrapolations from the data?

A. The -- we took whatever NAMCS data we could get. So, I -- there -- there's going to be some encounters where there are not many visits, and unfortunately, that's the best data you have relative to no data. So, there may be a particular drug -- NDC or a particular cell where there were four doctors' visits, and I'd certainly

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like to rely on 300 doctors' visits, but when four is all you have, it's better than saying it's 50/50 for purposes of not having any data.

Q. Okay. But you would agree that if the -- if you only have four, the chances of that being accurate, statistically, are lower than if you have, say, 300, is that right?

A. You'd always want to have more visits than less.

Q. All right. Now, shifting a second to your calculation of the units for each drug involved in your damage calculations, am I correct that you made an effort in the MDL and in Connecticut for physician-administered drugs --

A. Could we -- could we just stick with MDL?

Q. You're right. That's a bad question.

A. Yeah.

Q. Let's stick with MDL.

A. Okay.

Q. Am I correct in trying to determine the number of units involved in the case in the MDL

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for physician-administered drugs, your goal was to pull out of the databases the units that, in fact, ended up in a physician clinic, is that right?
A. We included oncology clinics. We -- we excluded hospitals. I have -- I'm speaking generally and -- well, specifically for hospitals. For staff model HMOs, we excluded those -- those units, and the exclusions are -- are clear in the description of the data that we used and how we got at the units. If it was an oncology clinic, that was -- and who submitted for reimbursement to third-party payers we -- they were included, we attempted to include those.
Q. Okay. When you had a situation in the database where you saw a sale to a wholesaler -- and before I ask my question, let me just ask a side question -- am I correct that that often happens --
A. It --
Q. -- many sales are directly to wholesalers?
A. Speaking generally -- generally, for all

1315

drugs many sales are to wholesalers, yes.
Q. All right. When you had a situation in the GSK data for Kytril and Zofran, the antiemetics where the sale was to a wholesaler and there was no charge-back that could trace it to a clinic physician market, there was no specialty distributor involved. It's simply a wholesaler sale, and you couldn't trace that sale to a hospital or any other market, would you have included or excluded those units in your analysis?
A. I would need -- we obviously used -- well, we -- not obviously, but as made clear in the discussion and in the attachments, we used the data from the wholesaler level, in re: charge-backs and a variety of measures to try and -- and to see what were sales that were either going to oncologists and doctors and which were going elsewhere. If there were a residual category for which we did not know, I would have to -- I'd have to confirm -- that would have to be a question I'd have to either look closely to the notes or confirm with my team.

1316

Q. All right. Am I correct, though, if there is a residual wholesaler sale category where you can't trace it to a physician clinic market, your goal would be to use whatever evidence you could only to include those wholesaler sales that ended up in the clinic physician market? Is that consistent with your approach?
A. In the provide -- in physician clinic provider market, that's correct.
MR. HEROLD: This is a good time to take a break.
MR. NALVEN: Do you believe that you've finished with your MDL questioning?
MR. HEROLD: Yes.
MR. NALVEN: Okay. Great.
VIDEO OPERATOR: The time is 1:05. This is the end of Cassette 2. We are off the record.
(Whereupon the deposition recessed at 1:05 p.m.)

1317

AFTERNOON SESSION (1:37 p.m.)

VIDEO OPERATOR: The time is 1:37. This is the beginning of Cassette 3 in the deposition of Mr. Raymond Hartman. We are on the record.
Q. Good afternoon, Doctor Hartman.
A. Good afternoon.
Q. I want to turn now to some questions about Connecticut, and I want to mark for the record your initial disclosure in Connecticut, dated November 1st, 2005.
(Disclosure, 11/1/05 marked Exhibit Hartman 060.)
Q. Doctor Hartman, is Exhibit Hartman 060 your initial disclosure report in Connecticut?
MR. NALVEN: This is counsel's disclosure, Fred.
MR. HEROLD: Okay.
A. (Witness reviews document.) This seems to be counsel's disclosure.
Q. Did you review that document before it was served in the Connecticut litigation?

1318

A. I did.
Q. You did not?
A. I did.
Q. You did.
A. Yeah, I did.
Q. Okay. Thank you. Now, Doctor Hartman, I think we established this morning that this particular document, this disclosure in the Connecticut case dated November 1st, 2005 does not contain drug-by-drug damage estimates applicable to the Connecticut case, is that correct?
MR. NALVEN: Objection.
A. It -- the calculations that I had submitted in January and February -- the calculation of damages, the first -- to Connecticut -- the first declaration in that calculation and then the supplemental, those were performed essentially using the methodologies put forward in this, but the -- they obviously are not contained in this -- in this disclosure.
Q. And why is it that you did not perform the damage calculations contained in your

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subsequent report prior to November 1st?
MR. NALVEN: Objection.
A. At the time that the -- the expert disclosure was submitted and I reviewed it, it formed the basis of my opinions and the methods I would use. I was still waiting to receive data from some of the Defendants on some of the drugs and still waiting to finalize certain understandings of the data so that the calculations could not be performed as they appear in the January and February submittals with the expert disclosure.
Q. Am I correct that with respect to GSK, you had received several computer databases containing GSK data, and in fact, all the GSK data that you relied upon ultimately in your January and February reports by February 25th, 2005?
A. I cannot recall the precise time. I could, of course, find that out when we did receive the data from -- from GSK. I -- an important part of the process of analyzing that data and making it ready for a calculation of

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damages that -- to be subject to -- to put before a court required the quality control on that data in terms of our being able to talk with members of -- of your client's staff and -- and anyone who could tell us more about the data.
It's my recollection that a final stipulation as to our understanding of all of the GSK data wasn't -- wasn't -- was not entered into until the day before this was due.
So, we were still -- while we had gotten the disks and the diskettes, there was a lot that was unclear to us with that data. We finally received a stipulation as of the day before this was due, and then obviously, I was still using the GSK data in -- for the MDL calculations that were submitted in -- in the December 15th report of 2005.
So, yes, we had the data, but it still was not ready for a -- a reasonable -- the quality control needed to be imposed upon it in order to rely on it for a calculation of damages.
Q. As of November 1st, 2005, had you

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received utilization data from the State of Connecticut with respect to any of GSK's drugs?
A. Again, I forget. I'd have to check with the staff. I don't remember the timing of when we were -- when.
Q. Have you received utilization data from the State of Connecticut as we sit here today?
A. Have we received utilization data from the State of Connecticut?
Q. Yes.
A. Yes.
Q. All right. And -- but you don't remember when you got it.
A. No. And that was also an evolving production. I mean, we'd receive some, and then we would talk to them and say, We looked at the CMS Web site. It doesn't look like that. And let's get this straight. And so, that was an ongoing process that had to be meshed with the process of the quality control on the manufacturer data that we received.
Q. Do you remember when you began receiving

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utilization data from either the State of Connecticut or its vendor, EDS?
A. I'd have -- I'd have to check with our -- no, I can't. No, I don't recall.
Q. Would you have a record of that that you could share with us?
A. I would have to look.
MR. HEROLD: Well, Counsel, I'm going to ask for that, and we'll follow up.
MR. NALVEN: Noted.
Q. Now, with respect to your January 19th report in the Connecticut case, which I believe is marked as Exhibit Hartman 055, am I correct that you signed that report on or about January 19th, 2006?
A. You are correct.
Q. Do you know when this particular report was provided to the Defendants in the Connecticut case?
A. If -- again, the -- there -- a variety of cases going on. If this is like any other case, it was provided to them the day before. It

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goes down to the wire, you're checking numbers, you're doing triple and quadruple checking. So, I would assume it was -- we're never able -- never able to get declarations done weeks ahead of time and let them sit on the shelf. That doesn't seem to be the way we are able to do it.
MR. HEROLD: All right. All right. I'd like to mark another exhibit.
(Letter, 2/13/06 marked Exhibit Hartman 061.)
Q. Doctor Hartman, I've marked for the record as Exhibit Hartman 061 a letter from your counsel, David Nalven, dated February 13th, 2006 to a number of attorneys who are among those attorneys who represent the Defendants in the Connecticut case. Have you ever seen this before?
A. I don't recall seeing it. I -- you know, it's whether -- I don't recall -- I don't recall seeing it.
Q. I'll ask you to take a second to read the brief text on the first page.
A. (Witness reviews document.) Here.

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Okay. I'm done with that.
Q. Okay.
A. Did you want me to go on?
Q. Yeah. My question is, are you aware or were you aware prior to this moment that your January 19th, 2006 report was not provided to the Defendants in the Connecticut case until this February 13th letter was sent out by overnight mail?
A. I don't really recall, you know, I'm sorry to say.
Q. Do you know any reason why that delay would have occurred?
A. No.
Q. And if you'll just take a look at the paragraph marked No. 4 on the second page, which lists as one of the items enclosed your February 9th, 2006 report. Do you see that?
A. I do.
Q. Were you aware that your February 9th, 2006 report in the Connecticut case was provided to the Defendants along with and at the same time

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as your January 19th report, both of which were provided by overnight mail on February 13th, 2006?
A. No, I did not.
Q. Was there any discussion with respect to not -- with you -- with respect to not providing the January 19th report until the February 9th alternative report had been completed?
A. No.
Q. Am I correct that the decision to prepare and submit the February 9th, 2006 report was communicated to you after you had already completed your January 19th, 2006 report?
A. I -- again, there's -- there are many cases going on, but I would -- I can't imagine that it -- that wasn't the case, but I don't -- I can't recall precisely.
Q. All right. So, you don't have -- do you have any recollection that before you signed off on your January 19th report on or around January 19th, your counsel said, Well, I'm going to ask you to do another one after this one's finished? Do you have any recollection of that kind of